Current Service Offerings

The next question for the Committee was whether existing services and funding allocations can meet future long-term care needs. To answer this question, the Committee first reviewed current programs and services within VA.

Long-term care represents about 13.8 percent of all VA healthcare expenditures. In total, VA long-term care services currently meet the care needs of 21.4 percent of Category A veterans requiring long-term care services. The Planning Model indicates that the need for VA long-term care will increase by 13 percent by 2002.

VA has a comprehensive array, or continuum, of long-term care services to meet veterans' care needs. The continuum includes VA-operated services, contract care, State Veterans programs, and services arranged by VA but financed by another payor. Program descriptions and utilization follow.

See Appendix D, Tables 3 and 4, for network-level cost and workload information.

VA-Operated Programs

VA Nursing Home Care

VANHs are hospital-based facilities designed to care for patients needing a comprehensive care management system coordinated by an interdisciplinary team. Services include nursing, medical, rehabilitative, recreational, dietetic, psychosocial, pharmaceutical, radiological, laboratory, dental, and spiritual care.

In 1997, VA operated 131 nursing homes and served an average daily census of 13,289 at a cost of $1.1 billion.

Home Based Primary Care

Home Based Primary Care (HBPC) is a special program providing primary healthcare in the home to a severely disabled, chronically ill population. The medical complexity of these homebound patients, as well as their functional impairment, make them unsuitable for management in an ambulatory setting. HBPC is different from most community home health agencies in its comprehensiveness and organization of services. Services include medical and nursing care, education, rehabilitation services, nutritional counseling, social work services, clinical pharmacy services, and bereavement counseling. HBPC also provides medications, supplies, medical equipment, and assistance with home improvements and structural alterations. At affiliated medical centers, HBPC provides essential training in primary long-term care to medical residents, geriatric fellows, nurses, and allied health professionals.

In 1997, HBPC programs at 73 sites served an average daily census of 5,531 at a cost of $58.5 million.

Average Daily Census

1990	11,787
1994	13,504
1997	13,289

VA Nursing Homes

Average Daily Census

1990	4,818
1994	5,069
1997	5,531

Home Based Primary Care

Adult Day Health Care

Adult Day Health Care (ADHC) is a therapeutic outpatient day program providing health maintenance and rehabilitative services to frail elderly people in a congregate setting. Individualized programs of care help participants and their caregivers develop the knowledge and skills necessary to manage care requirements at home.

In 1997, VA operated 14 ADHC programs at 14 sites and served an average daily census of 434 at a cost of $7.7 million.

Average Daily Census

1990	425
1994	420
1997	434

VA Adult Day Health Care

VA Domiciliary Care

A VA domiciliary is a residential rehabilitation and health maintenance center for veterans who do not require hospital or nursing home care but are unable to live independently because of medical or psychiatric disabilities.

VA is actively exploring the establishment of enriched housing/assisted living at VA facilities through the Enhanced Use Leasing Program.

Average Daily Census

1990	6,526
1994	6,051
1997	5,461

VA Domiciliary Care

In 1997, VA operated 40 domiciliaries and served an average daily census of 5,461 at a cost of $200.8 million.

Respite Care

Respite care is designed to relieve a spouse or other caregiver from the burden of caring for a chronically ill and disabled veteran at home. This is accomplished by admitting the veteran to a VA hospital or nursing home for planned, brief periods of care.

In 1997, there were 136 respite care programs with an average daily census of 680 at an estimated cost of $24.3 million.

VA Contract Programs

Community Nursing Home Program

The CNH program places patients requiring nursing home care in community nursing facilities at VA expense. All VA facilities have CNH capability. The target population for the CNH program includes patients who require care in nursing homes due to ADL impairments; medical diagnoses; and/or the inability of the informal and formal care system to provide care at home or in the community.

In 1997, VA contracted with 3,700 community nursing homes serving an average daily census of 6,477 at a cost of $316.8 million.

Average Daily Census

1990	8,435
1994	8,783
1997	6,477

Community Nursing Home

Contract Adult Day Health Care

The Contract Adult Day Health Care (CADHC) program places patients in day health settings, providing health maintenance and rehabilitative services to frail elderly people, at VA expense. CADHC serves patients who live in the program's primary service area with reliable transportation, who need ADHC services, and meet specific admission criteria.

In 1997, CADHC programs at 83 sites served an average daily census of 551 at a cost of $9.8 million.

Average Daily Census

1990	250
1994	579
1997	551

Contract Adult Day Health

Contract Home Health Care

Professional home healthcare services, mostly nursing services, are purchased at every VA medical center. The program is commonly called "fee basis" home care.

In 1997, expenditures for the Contract Home Health Care program were $46.9 million, with an average daily census of 2,336.

Average Daily Census

1990	-
1994	1,421
1997	2,336

Contract Home Healthcare

Homemaker/Home Health Aide Services

VA contracts for homemaker and home health aide services for veterans who need a nursing home level of care but can be maintained at home with the support of these services, often in conjunction with professional home healthcare.

In 1997, 118 VA medical centers purchased homemaker/home health aide services with an average daily census of 2,581 at a cost of $31.3 million.

Average Daily Census

1990	-
1994	1,500
1997	2,581

Homemaker/Home Health Aide

Community Residential Care

The Community Residential Care (CRC) program provides room, board, outpatient care, and limited personal supervision at the veteran's expense, along with home visits by VA nurses and social workers. The CRC program targets patients who, due to medical and/or psychosocial health conditions, cannot live independently and have no suitable family or significant others to provide supervision and necessary care.

In 1997, VA had arrangements with 2,100 CRC facilities and served an average of 9,086 veterans on a daily basis at an administrative cost of $11.8 million.

Average Daily Census

1990	11,000
1994	11,500
1997	9,086

Community Residential Care

State Veterans Homes

State Veterans Home Program

A State Home is a home approved by VA that has been established by a state for veterans disabled by age, disease, or otherwise who, due to disability, are incapable of earning a living. State Homes include facilities for domiciliary and/or nursing home care. Hospital care may be included when provided in conjunction with domiciliary or nursing home care. A State Home also may provide care to veterans' family members. Recently, the State Veterans Home Program was authorized to provide Adult Day Health Care services.

This program is a partnership among VA, the states, and veterans. VA participates in two grant programs with State Homes. One grant allows VA to participate in the construction and renovation of a State Home with up to 65 percent of the construction costs. The per diem grant program allows VA to subsidize a portion of the daily cost of care.

Average Daily Census

1990	9,438
1994	11,369
1997	14,039

State Nursing Homes

In 1997, there were 86 State Veterans Nursing Homes in 39 states with an average daily census of 14,039. The cost was $202.1 million. For the same period, there were 47 State Veterans Domiciliaries in 31 states with an average daily census of 3,584, at a cost of $21 million.

Average Daily Census

1990	3,732
1994	3,517
1997	3,584

State Domiciliary

Mental Health Services

VA has an extensive mental healthcare system that serves thousands of chronically mentally ill veterans. The care of patients receiving long-term psychiatric interventions within the mental health system was not evaluated by the Committee, as it was beyond the scope of the Committee's charge.

Many patients in nursing homes, domiciliary, and home- and community-based programs need mental health services. In a 1994 survey of VANHs, 37 percent of patients had dementia, 18 percent had depressive disorders, 15 percent had alcohol dependency/abuse conditions, and 14 percent had schizophrenia.

VA has responded to these needs with a series of national training conferences to develop strategies for caring for patients with mental illness. Seventy VANH teams, composed of physicians, psychiatrists, psychologists, nurses, social workers, and nursing assistants, have attended. VA domiciliary staff also has received extensive training in mental health issues.

VA needs to expand its long-term care/mental health collaborations beyond VANHs and domiciliaries. Opportunities abound for enhancing mental healthcare, particularly in community nursing homes, State Veterans Homes, community residential facilities, home based primary care, and adult day healthcare settings.

Nursing Home Operations

Nursing home care receives the largest allocation of the long-term care budget. In light of this, the Committee examined this program at length, both in terms of cost and program benefits.

Cost of Care

Compared with other long-term care options, VANHs are expensive to operate. In FY 1997, the reported average daily per diem cost for VANHs was $235.30. In CNHs, the daily per diem was $134.10. The federal per diem grant for State Veterans Nursing Home Care was $40, or 28.9 percent of the national average per diem cost in these homes.

A 1995 cost study by the Health Services Research and Development (HSR&D) Program at VA Bedford examined the reasons for the per diem differences between VANHs and CNHs. While the study was unable to explain all the cost differences, it did offer important information about both programs. The study, *Nursing Home Cost Study: A Comparison of VA Nursing Homes and Contract Nursing Homes*, found that the cost differential between VANHs and CNHs was over-reported by as much as 26 percent. Cost differences varied widely by geographic regions. In the South, VANHs were $37.31 per patient day more expensive than CNHs; in the Central states, the cost differential was $46.80 per patient day; and the difference was $53.30 per patient day in the West. Cost differences between VANHs and CNHs were not statistically significant in the East.

The study also found that the mean case-mix score of patients in VANHs was 33 percent higher than patients in CNHs. Special rehabilitation patients were 16 percent of the VANH population and only 3 percent of the CNH population. Patients with behavior problems were 3 percent of the VANH population, but 11 percent of the CNH population.

Staffing differences also were pronounced. Registered nurses represented 36 percent of the nurse staffing in VANHs and just 12 percent of the nurse staffing in CNHs. Licensed practical nurses represented 32 percent of nurse staffing in VANHs and 22 percent in CNHs. Nurses' aides were 32 percent of the nurse staffing in VANHs and 67 percent in CNHs.

Although the study explained less than half of the cost differential, some conclusions are warranted. Except for the eastern region of the country, nursing home placement must be evaluated. For VANHs in the central, southern, and western areas, this could include nurse staffing adjustments or changes in case-mix.

Length of Stay

The cost of nursing home care has led to concerns about lengths of stay (LOS) in the VANH and CNH programs. In VANHs, life care has been promised to some veterans. Shorter planned placements in VANHs and more aggressive discharge planning are at odds with this promise. Also, some patients require long-term care in a VANH setting. At the same time, concerns have been raised about insufficient planning to transition patients from VANHs to community nursing home or home- and community-based care.

Cost concerns and the discretionary nature of nursing home eligibility also has led to questionable changes in the placement of veterans in the CNH program. Statutory authority allows VA to pay for CNH care for up to six months for nonservice-connected conditions and for a longer term for certain service-connected conditions.

Based on staff reports and LOS data, these options have become increasingly constrained for veterans in many areas of the country. Nonservice-connected veterans

frequently receive only 30 to 60 days of CNH care at VA expense, regardless of care needs. In some networks, service-connected veterans who need nursing home care for service-connected disabilities also have been limited to 30 days of VA-paid care.

To address patient concerns regarding life care and discharge planning/transition, VA has published *Policy Guidelines for Continuity of Care Planning for VA Long-Term Care Inpatient Units* (November 1997). These guidelines highlight principles for transition planning and special considerations for clinical, patient-specific, family, community provider, and institutional issues.

Nursing Home Construction

In an era of limited budgetary resources, expansion of nursing home care has a lower priority than the expansion of home- and community-based care. VA appears to have a sufficient number of nursing home beds to continue to meet its historic share of nursing home needs. However, necessary renovation for patient privacy and life safety in VANHs and State Veterans Homes will continue. Future increases in nursing home care needs can be accommodated through CNHs.

Care Coordination

Care coordination is the mechanism for managing access to, and delivery of, needed and appropriate healthcare services. The care coordinator is accountable for the appropriate delivery of services. Access to appropriate and timely care in the appropriate setting leads to improved quality of care. Cost efficiencies are expected from reductions in hospitalizations.

The foundation of care coordination is a robust assessment of a patient's medical and physical status. Not all patients or even all long-term care patients require ongoing care coordination. With its strong tradition in patient assessment through its Geriatric Evaluation and Management Programs (GEMs) and a vertically integrated healthcare system, VA is poised to provide effective coordination services. In practice, care coordination in VA long-term care has been very successful where it has been well-integrated into programs and services. Many VA facilities have yet to fully implement a care coordination mechanism for long-term care services.

As VA moves toward implementation of a standard benefits package for an enrolled patient population, the importance of care coordination for long-term care patients, with strong links to acute and primary care, becomes even more important.

Implications

VA has a wide range of services for veterans. However, not all services are available around the country, and VA eligibility limits the number of veterans who receive VA long-term care services. As a result, most veterans, including Category A veterans, utilize other systems — such as Medicare and Medicaid — for long-term care services. VA long-term care mirrors the community distribution of long-term care services (nursing home versus home- and community-based care), but lags behind cutting edge state programs. In addition, VA's nursing home programs need restructuring. While VA has an adequate investment in nursing home care, serious consideration of the size and nature of the programs, especially VANH, is indicated. However, VANHs are recognized nationally as high quality facilities, in large part because of their highly trained and experienced staff. Therefore, any changes in program staffing structure should be carefully managed. Other changes in program structure can be implemented without relocating veterans who have resided in VANHs for many years. Finally, care coordination can be an effective tool to manage access to services while achieving cost efficiencies.

- VA should expand options and services for home- and community-based care, making these services the preferred placement site, when clinically appropriate, for veterans needing long-term care. The service mix should be based on the care needs of the veteran population and the availability of services in local communities.

- VA should increase its investment in enriched housing and home- and community-based care from 2.5 percent to 7.5 percent of the total VA healthcare budget.

- Within VA long-term care spending, the proportion of home- and community-based care and enriched housing should double — to 35 percent of total long-term care expenditures.

- Additional educational efforts and other collaborative ventures between long-term care and mental health program staffs are strongly encouraged.

- VA needs to maintain its three nursing home programs. Home- and community-based services cannot substitute for nursing home care for most of the veteran population. VA should use its own hospital-based nursing home beds to provide care to post-acute patients, patients who cannot be cared for in other nursing home programs, and those patients who can be cared for more efficiently in VANHs.

- VA should implement and enhance its existing written policies on CNH placement. Length of CNH placements should be based on patient care needs, not fiscal goals.

- In FY 1997, 12.3 percent of veterans in VANHs had lengths of stay in excess of one year. VA should take necessary steps to ensure that VANH patients who no longer require hospital-based nursing home care are properly transitioned into other nursing home or home- and community-based care programs. Patients who require long-term care, have received care for more than 1,000 days, and desire to remain in the nursing home, should be allowed to remain in the VANH.

- In an era of limited budgetary resources, VA should not seek funding for any new nursing home beds, except for approved projects that are justified by objective standards that include a measure of community capacity and national policy goals. Renovation projects that affect the number of beds also should be rejustified. Renovation projects that affect patient privacy and life safety issues should receive first priority.

- VA should establish system-wide care coordination processes, based on a comprehensive assessment of patients requiring long-term care services. A standardized core assessment, upon which VISNs or facilities can add criteria to meet individual objectives or target improvements, should be the baseline. VA should reassign and train existing staff to implement such processes.